Patient's Name: First _____ Last _____ Middle Initial _____

Preferred Name _____ Date of Birth _____ □ Male □ Female

How did you hear about our office? _____

Patient Medical History

	Yes	NO		Yes	NO
Heart Murmur/Heart Disease	□	□	Speech/Occupational Therapy	□	□
Cardiac Pacemaker	□	□	Asthma	□	□
Autism Spectrum	□	□	Tuberculosis/Lung Disease	□	□
High Blood Pressure	□	□	Epilepsy	□	□
Rheumatic Fever	□	□	Nervous Disorder	□	□
Prolonged Bleeding When Cut	□	□	HIV/ AIDS	□	□
Blood Transfusion, Date _____	□	□	Metallic Implant	□	□
Cancer, Tumor	□	□	Glaucoma	□	□
Kidney Disease	□	□	Female patient's, are you pregnant?	□	□
Diabetes	□	□	Chemical Dependency	□	□
Hepatitis /Liver Disease	□	□	Tobacco User	□	□
Thyroid Disease	□	□	Bone Density Medication (Ex: Fosomax)	□	□
Latex Allergy	□	□	Sensory Issues	□	□

Is there any Drug/ Food/ Metal Allergy? If Yes, to what medications/foods

_____

Is there any other health information that should be known? _____

Are you taking any medications/ vitamin supplements/ recreational drugs? □ YES □ NO

If yes, please list the medications & reasons:

_____

Have you recently been under the care of a physician or had a serious illness or operation in the last 5 years?
□ YES □ NO If yes, please explain

_____

Name & phone number of your physician:_____

Have you experienced any unfavorable reaction from any previous dental or medical care? □ YES □ NO
If yes, please explain

_____

Emergency Contact & Consent to Release Information

I give my consent to allow the release of healthcare information or to secure payment on my behalf to the following persons and I understand I can revoke this consent at any time by providing written notice.
Persons who have consent in my absence are 1)

2)

Name & Phone of nearest relative not living with you _____

I give my consent Dr Mark Feinberg of Mark Feinberg Orthodontics to perform a complete oral examination on the patient named previously. X-rays that are necessary may be taken. Any additional treatment received will be fully explained at each visit.

Insurance portions are an estimate based on information released by my insurance company. IT DOES NOT GUARANTEE PAYMENT. I am aware that the insurance coverage is a contract between me and my carrier. As a courtesy, claims may be filed on my behalf. Should any dispute occur or if I fail to provide accurate information, I understand I am financially responsible to the doctors for all dental treatment.

I agree to inform the doctor of any changes in medical or financial information. I acknowledge that I have read the Notice of Privacy Act and that a copy will be made available to me upon request.

X _____

Sign Date

Previous Dental History

Last Dental Visit & Reason: _____

Dentist's Name & Phone Number: _____

Does the patient have a specific dental problem that needs attention? □ YES □ NO If yes, please explain

_____

Has any member of your family received dental treatment in this office before? Names:_____

Orthodontic Section

Patient's Current Dentist
Name & Phone Number _____

Has an orthodontist been previously consulted? □ YES □ NO Dr's Name: _____

Chief Concerns:

□ Crowding □ Overbite □ Shifting/ Relapse of teeth
□ Spaces □ Underbite □ Dental Referral
□ Missing teeth □ TMJ Pain □ Oral Habits/ Tongue Thrust
□ Headaches on a regular basis
□ Other: _____

Responsible Party Information

Patient Name _____ _____ _____ _____
Last First Middle Initial Marital Status Driver's License #

Address _____
Street City State Zip

How long at this address _____ Primary Phone_____ Secondary Phone _____

Email Address_____ Social Security # _____ Date of Birth _____

Employer_____ Occupation _____ Years Employed _____

Work Phone & Ext _____ Preferred Method of Contact : Email____ or Phone _____ please check one

Spouse's Name _____ _____ _____ _____
Last First Middle Initial Marital Status Driver's License #

Address (if not the same) _____
Street City State Zip

How long at this address _____ Primary Phone_____ Secondary Phone _____

Email Address_____ Social Security # _____ Date of Birth _____

Employer_____ Occupation _____ Years Employed _____

Work Phone & Ext _____ Preferred Method of Contact : Email____ or Phone _____ please check one

Dental Insurance Information

Insured's Name _____ Insured's ID # _____ Birth Date_____

Primary Insurance Company_____ Group #_____ Effective Date_____

Insurance Co. Phone # _____ Insured's Employer _____

Do you have dual coverage? □ Yes □ No If Yes:

Insured's Name _____ Insured's ID # _____ Birth Date_____

Secondary Insurance Company_____ Group #_____ Effective Date_____

Insurance Co. Phone # _____ Insured's Employer _____